COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES

PROVIDER AGENCY ADVISORY COMMITTEE

MEETING NOTICE

DATE: **December 21, 2016**

TIME: **1:00 pm**

LOCATION: **Los Angeles County EMS Agency**
EMS Commission Hearing Room – 1st Floor
10100 Pioneer Boulevard
Santa Fe Springs, California 90670

The Provider Agency Advisory Committee meetings are open to the public. You may address the Committee on any agenda item before or during consideration of that item, and on other items of interest that are not on the agenda, but are within the subject matter jurisdiction of the Committee.

AGENDA

CALL TO ORDER

1. **APPROVAL OF MINUTES – October 19, 2016**
2. **INTRODUCTIONS / ANNOUNCEMENT**
   - **2.1** Certification and Accreditation Fees
3. **REPORTS & UPDATES**
   - **3.1** EMS Update 2017
4. **UNFINISHED BUSINESS**
   - **4.1** No unfinished Business
5. **NEW BUSINESS**
   - **5.1** Reference No. 702, Controlled Drugs Carried On ALS Units *(Information Only)*
   - **5.2** Reference No. 1200, Treatment Protocol: Table of Contents
   - **5.3** Reference No. 1200.1, Treatment Protocol: General Instructions
   - **5.4** Reference No. 1201, Treatment Protocol: General ALS
   - **5.5** Reference No. 1201-P, Treatment Protocol: General ALS *(Pediatric)*
   - **5.6** Reference No. 1270, Treatment Protocol: Airway Obstruction
6. **OPEN DISCUSSION**
7. **NEXT MEETING: February 15, 2017**
8. **ADJOURNMENT**

County of Los Angeles
Department of Health Services

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES COMMISSION

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, October 19, 2016

MEMBERSHIP / ATTENDANCE

MEMBERS	ORGANIZATION
☑ Dave White, Chair	EMSC, Commissioner
☑ Robert Ower, Vice-Chair	EMSC, Commissioner
☐ *LAC Ambulance Association*	EMSC, Commissioner
☐ *LAC Police Chiefs' Association*	EMSC, Commissioner
☑ Jodi Nevandro	Area A
☑ Sean Stokes	Area A Alt (Rep to Med Council, Alt)
☑ Nick Berkuta	Area B
☑ Clayton Kazan, MD	Area B, Alt.
☐ Victoria Hernandez	Area B Alt. (Rep to Med Council)
☑ Ken Leasure	Area C
☐ Susan Hayward	Area C, Alt
☑ Richard Roman	Area E
☐ Mike Beeghly	Area E, Alt.
☑ Josh Hogan	Area F
☑ Joanne Dolan	Area F, Alt.
☐ Mike Hansen	Area G (Rep to BHAC)
☑ Michael Murrey	Area G, Alt. (Rep to BHAC, Alt.)
☐ Corey Rose	Area H (Rep to DAC)
☐ Miguel Escobedo	Area H, Alt.
☑ Adam Richards	Employed EMT-P Coordinator (LACAA)
☐ VACANT	Employed EMT-P Coordinator, Alt. (LACAA)
☐ Jenny Van Slyke	Prehospital Care Coordinator (BHAC)
☑ Alina Chandal	Prehospital Care Coordinator, Alt. (BHAC)
☑ Andrew Respicio	Public Sector Paramedic (LAAFCA)
☐ James Michael	Public Sector Paramedic, Alt. (LAAFCA)
☑ Maurice Guillen	Private Sector EMT-P (LACAA)
☐ Scott Buck	Private Sector EMT-P, Alt. (LACAA)
☐ Marc Eckstein, MD	Provider Agency Medical Director (Med Council)
☐ Stephen Shea, MD	Provider Agency Medical Director, Alt. (Med Council)
☑ Diane Baker	Private Sector Nurse Staffed Ambulance Program (LACAA)
☐ Vacant	Private Sector Nurse Staffed Ambulance Program, Alt (LACAA)

EMS AGENCY STAFF PRESENT	
Cathy Chidester	Richard Tadeo
Christ Clare	Susan Mori
Christy Preston	Paula Rashi
David Wells	Cathlyn Jennings
Sara Rasnake	Yvonne Elizarraraz
Lorrie Perez	Karen Rodgers
Gary Watson	

OTHER ATTENDEES	
Kris Thomas	Ambulnz Ambulance
Nick Erickson	Ambulnz Ambulance
Barry Snyder	LACoFD Life Guard
Kyle Power	LACoFD Life Guard
Drew Bernard	Emergency Ambulance
Ian Wilson	PRN Ambulance
Monica Bradley	Culver City FD
Tisha Hamilton	AMR Ambulance
Julian Zermeno	Santa Monica FD
Roger Braum	Culver City FD
Ellsworth Fortman	LAFD
Caroline Jack	Torrance FD
Mike Barilla	Pasadena FD
Trevor Stonum	MedCoast Ambulance
Nicole Steeneken	LACoFD
Yuh Son Kim	LACoFD
William Gonzales	AmbuService Amb
John Pringle	
Ben Esparza	
Nanci Medina	

LACAA – *Los Angeles County Ambulance Association* * LAAFCA – *Los Angeles Area Fire Chiefs Association* * BHAC – *Base Hospital Advisory Committee* * DAC – *Data Advisory Committee*

CALL TO ORDER: Chair, Commissioner Dave White called meeting to order at 1:05 p.m.

1. APPROVAL OF MINUTES: (Berkuta/Leasure) August 17, 2016 minutes were approved as written.

2. INTRODUCTIONS / ANNOUNCEMENTS

None

3. REPORTS & UPDATES

3.1 EMS Update 2017 *(Richard Tadeo)*

- The EMS Agency is requesting representatives from Base Hospital Advisory Committee and Provider Agency Advisory Committee to join a workgroup that will assist with the planning of EMS Update 2017.

- Topics currently being considered include: primary and secondary impressions, pediatric protocols, and development of a mobile app for the treatment protocols,
- Those interested in participating in the EMS Update 2017 workgroup, may contact Richard Tadeo.

3.2 2016 EMS Data Report *(Richard Tadeo)*

- Recently published Data Report was reviewed.
- This Annual EMS Data Report is currently available on the EMS Agency's webpage; printed copies will soon be available.

3.3 Comprehensive Stroke Center *(Richard Tadeo)*

- The EMS Agency is currently developing Agreements and Standards for the Comprehensive Stroke Center (CSC).
- CSCs will be required to secure an Agreement with transport providers, which would reduce the need to activate 9-1-1 for secondary transportation.
- Target date to implement CSC is March/April 2017. It is expected that approximately 6-7 hospitals will be ready to participate.

3.4 Standardized Drug Formulary *(Richard Tadeo)*
3.5 Reference No. 1309, Medical Control Guideline: Color Code Drug Doses *(Richard Tadeo)*

- Education for these topics have already been distributed.
- Due to concerns identified related to medications, the EMS Agency will be sending out a memo to all providers that will further clarify the following medications: Atropine, Sodium Bicarbonate, Naloxone (Narcan) and Dextrose 10%.
- Committee identified other concerns and requested that the implementation of the Standardized Drug Formulary and Color Code Drug Doses be postponed until EMS Update 2017.
- The EMS Agency will provide notification to all providers on decision to either move forward or postpone the implementation of the Drug Formulary and Reference No. 1309.

4. UNFINISHED BUSINESS

No unfinished business.

5. NEW BUSINESS

5.1 Reference No. 510, Pediatric Destination *(Karen Rodgers)*

Policy reviewed and approved with the following recommendations:

- Page 3 of 3, Policy II, G: add examples of "Focal neurologic signs", including atypical migraine, pediatric stroke, and small focal/petite mal seizures
- Page 3 of 3, Policy II: add Section H, "Choking associated with cyanosis"
- Include policy in EMS Update 2017

M/S/C (Kazan/Nevandro): Approve Reference No. 510, Pediatric Patient Destination.

5.2 Reference No. 516, Return of Spontaneous Circulation (ROSC) Patient Destination *(Paula Rashi)*

Policy reviewed and approved as written.

M/S/C (Berkuta/Leasure): Approve Reference No. 516, Return of Spontaneous Circulation (ROSC) Patient Destination.

5.3 Reference No. 911, Public Safety First Aid (PSFA) and Basic Tactical Casualty Care (BTCC) Training Program Requirements *(Richard Tadeo, Cathy Chidester, David Wells)*

Policy reviewed and approved as written.

M/S/C (Hogan/Murrey): Approve Reference No. 911, Public Safety First Aid (PSFA) and Basic Tactical Casualty Care (BTCC) Training Program Requirements.

6. OPEN DISCUSSION:

None.

7. NEXT MEETING: December 21, 2016

8. ADJOURNMENT: Meeting adjourned at 1:58 p.m.

EMS Update 2017 Summary

December 1, 2017

Train-the-Trainer Sessions:

Monday afternoon; April 24, 2017; 1PM-4PM; EMS Agency Hearing Room
Thursday morning; April 27, 2017; 9AM-12PM; EMS Agency Hearing Room
Thursday afternoon; April 27, 2017; 1PM-4PM; EMS Agency Hearing Room

Training Period:

May 1, 2017 through July 31, 2017

Topics:

1. Provider Impressions – in depth discussion on the State approved provider impressions, organized by body systems for LA County, utilize differential diagnosis, and introduction to a new design and format of the treatment protocols

2. Case studies – incorporate new treatments, review key system changes, utilize provider impressions, incorporate differential diagnosis, and address inappropriate downgrades.
   Base Hospitals are requested to submit base contact audio that would enhance the presentation of the various case studies described below. Please submit potential case studies to Richard Tadeo by January 15, 2017.

   a. Non-Traumatic Body Pain – address pain assessment, management , transport decisions
      Potential case: young male with kidney stone, 1st trimester with RUQ pain

   b. Chest Pain – differentiate between STEMI, suspected cardiac and non-cardiac chest pain

   c. Hypotension/Shock – utilization of push dose epinephrine – case of non-traumatic shock not responsive for fluid resuscitation

   d. Behavioral/Psychiatric Crisis – differentiate between violent and psychiatric crisis, address appropriate assessment and management – two cases – one schizophrenia – the other agitated delirium

   e. Hypoglycemic emergencies – replace D50 with D10 for all patients (including adults)

   f. Pulmonary Edema – differential diagnosis
      Potential case: patient with CHF requiring CPAP

   g. Respiratory Distress – differential diagnosis
      Potential case: unclear breath sounds, dyspnea with decrease breath sounds

   h. Stroke – assessment, management and destination
      Potential case: mLAPSS and LAMS positive

   i. BRUE – Brief Resolved Unexplained Events

   j. Seizure Activity – assessment and management for active and post seizure activity

   k. Crush Injury – assessment and management

SUBJECT: **CONTROLLED DRUGS CARRIED ON ALS UNITS** REFERENCE NO. 702

PURPOSE: To ensure accountability for all controlled drugs issued to ALS units.

AUTHORITY: Health and Safety Code, Chapter 5, 1797.220 and 1798
California Business and Professions Code, Section 4005 and 4119(4)(5)
Department of Justice, DEA Regulations, Title 21, Code of Federal Regulations, Section 1300 – ~~1360~~ END
Controlled Substances Act, 21 USC 801-890

PRINCIPLES:

1. Effective controls and procedures are essential to guard against theft and diversion of controlled substances due to the risks associated with mishandling these drugs.

2. Controlled drugs will be restocked only with a full account of drugs administered, wasted, or lost.

3. Controlled drugs issued from County-operated pharmacies are intended for use within Los Angeles County except as otherwise specified in this policy. County-issued controlled drugs remain the property of Los Angeles County after being issued to paramedic provider agencies and when carried on ALS units.

4. Providers may only carry one narcotic analgesic on the ALS units. Provider Agency Medical Directors may request to carry Fentanyl by contacting the EMS Agency's Medical Director.

5. Provider agencies may utilize an Automated Dispensing System (ADS) for storage and dispensing of controlled substances.

QUANTITIES OF CONTROLLED DRUGS TO BE CARRIED ON ALS UNITS:

Fentanyl: 100mcg unit dose, minimum amount 500mcg not to exceed 1500mcg unless otherwise approved by the EMS Agency Medical Director, ~~the Provider Agency Medical Director or as dictated by supply.~~

Morphine sulfate: 4mg unit dose, minimum amount 32mg not to exceed 60mg unless otherwise approved by the EMS Agency Medical Director, ~~the Provider Agency Medical Director or as dictated by supply.~~

Midazolam (Versed®): 5mg unit dose, minimum amount 20mg not to exceed 40mg unless otherwise approved by the EMS Agency Medical Director, the Provider Agency Medical Director, ~~the Provider Agency Drug Authorizing Physician or as dictated by supply.~~

APPROVED: _____ _____
Director, EMS Agency Medical Director, EMS Agency

POLICY:

I. Provider Agencies May Obtain Controlled Drugs Through:

A. A County operated hospital pharmacy (with approval from the EMS Agency) utilizing the procedure outlined in this policy.

B. A Provider Agency Medical Director who meets the qualifications of Reference No. 411, Provider Agency Medical Director if they agree to authorize such procurement or a Provider Agency Drug Authorizing Physician as outlined in Reference. No. 410, Drug Authorizing Physician for Provider Agencies.

II. Controlled Drug Resupply Through a County Operated Hospital Pharmacy:

A. EMS Agency responsibilities:

1. Assign each provider agency that chooses to resupply controlled drugs through a County operated hospital to one or more County facilities.

2. Supply each provider agency with a locked bag in which to store controlled drugs while in transit between the pharmacy and the provider agency.

3. ~~Resupply controlled drugs on a one-for-one basis utilizing the procedure outlined in this policy.~~

4. Report the theft or loss of any controlled substances to the issuing pharmacy, whether or not the controlled substances are subsequently recovered and/or the responsible parties are identified and action taken against them.

B. Provider Agency Responsibilities:

1. Provider agency controlled drug policies and procedures shall be consistent with ~~Ref. No. 702~~ this policy and be submitted to the EMS Agency for initial review and approval. Any subsequent changes to policies and procedures must be submitted to the EMS Agency for review and approval.

2. Provide the County pharmacists with the names and original signatures of individuals authorized to pick up and transport controlled drugs. A copy of this document shall be provided to the EMS Agency.

a. Submit a single list of names (not copies of drivers' licenses or other ID cards) on departmental or company letterhead.

b. Update the list annually, no later than June 30th .

3. Identify, in the provider agency's internal policy, one or more individuals responsible for the key to the controlled drug transit bag. The County pharmacist will maintain a second key at the pharmacy.

4. Ensure that the on-duty paramedic is responsible for the security of the drugs at all times. If the department uses a non-key system, such as a keypad or padlock type, the internal controlled substance policy should

indicate how the combination is kept secure. Ensure adequate security to guard against theft and diversion during controlled drug transport and distribution.

5. Utilize County-issued controlled drugs outside of Los Angeles County only in the event of wildfires, disasters, terrorist responses or other unanticipated events.

6. Restock controlled drugs only from the assigned Department of Health Services (DHS) pharmacy to prevent intermingling of controlled drug stock.

7. Provider agencies using an EMS Agency approved electronic patient care record (ePCR) will develop a process/procedure, approved by the EMS Agency and the assigned County Pharmacy, on the type of paper documentation required for medication replacement.

8. Resupply controlled drugs on a one-for-one basis utilizing the procedure outlined in this policy.

C. Replacement Procedure for Controlled Drugs Administered in the Field:

1. Providers shall:

a. Present the blue copy of the EMS Report Form, or ePCR or a uniquely identifiable document for each patient to whom a controlled drug was administered.

b. Present a photo identification (employee ID, driver's license, etc.) to verify identity at the pharmacy.

2. Pharmacists shall:

a. Stamp and initial the blue copy of the EMS Report Form (or ePCR document) utilizing the EMS Agency-issued stamp.

b. Replace the controlled drugs utilizing the locked transport bag.

c. Return the blue copy (or the ePCR documentation) to provider agency personnel.

D. Replacement Procedure for Expired or Broken Controlled Drugs:

1. Provider agencies shall:

a. Complete Reference No. 702.1, Expired/Broken Controlled Drug Pharmacy Reporting Form and maintain a copy in the provider agency's controlled drug file.

b. Present the completed Reference No. 702.1 to the issuing pharmacy along with the expired drug(s) for disposal in accordance with all applicable state and federal regulations.

c. If requesting replacement of controlled drugs due to breakage, complete Ref. No. 702.1 and provide the broken container to the issuing pharmacy.

2. Pharmacists shall:

Replace the controlled drug following their facility's approved procedure.

E. Replacement Procedure when the Blue Copy of the EMS Report Form (or the ePCR) is Missing:

1. Paramedics shall notify the on-duty captain, battalion chief or supervisor that the blue copy is missing. A written report summarizing the incident shall be submitted to the EMS Agency that:

a. Describes what happened to the Blue Copy of the form (or the ePCR).

b. Is signed and dated by the reporting party, the on-duty captain or supervisor, the battalion chief or general manager.

2. The incident report and a copy of the EMS Report Form shall be forwarded to the paramedic coordinator or the individual responsible for controlled drug procurement.

3. The paramedic coordinator or responsible individual shall review the documents and hand deliver copies to the EMS Agency.

4. EMS Agency staff shall review and validate the documents and generate a letter to the provider agency's assigned County pharmacy authorizing replacement of the controlled drugs. The original copy of the authorization, which expires in 14 days, is ~~handed~~ provided to the paramedic coordinator or responsible individual to hand carry to the pharmacy.

III. Controlled Drug Replacement Through a Non-County Supplier:

A. Provider agencies that have requested EMS Agency oversight of their controlled drug program shall develop policies and procedures, approved by their Provider Agency Medical Director and/or Drug Authorizing Physician, to ensure that all controlled drugs are obtained, maintained, and distributed in a secure manner consistent with local, state, and federal regulations.

B. Such policies and procedures shall be submitted to the EMS Agency for review and approval unless the Provider Agency Medical Director/Drug Authorizing Physician wants to assume sole responsibility for procurement, storage and security of controlled substances. In that case, the Provider Agency Medical Director and Provider Agency Fire Chief (or CEO/President) shall submit Ref. No. 702.4, Provider Agency Medical Director Notification of Controlled Substance Program Implementation.

C. Provider agencies that operate a controlled drug program without EMS Agency oversight shall submit Ref. No. 702.4 under the following circumstances:

1. Upon initial request to develop a controlled drug program without EMS Agency oversight.

2. At the time of the EMS Agency annual program review.

3. Any change in the provider agency medical director.

IV. Controlled Drug Security

A. Controlled drug security requirements apply to all provider agencies, whether drugs are ordered through the Provider Agency Medical Director, Drug Authorizing Physician or the EMS Agency Medical Director.

B. Paramedics assigned to an advanced life support (ALS) unit shall be responsible for maintaining the correct controlled drug inventory and security of the narcotic keys (or confidentiality of the keypad/padlock combination) for their assigned unit at all times.

C. Controlled drugs shall not be stored in any location other than on ALS units unless authorized by the EMS Agency. The initial authorization process requires EMS Agency inspection of the storage facility and approval of the provider agency internal policy specifying the location, security, access and procedure for obtaining drugs from the controlled drug cache. (This requirement does not apply to provider agencies that meet the terms of Ref. No. 702.4, Provider Agency Medical Director Notification of Controlled Substance Program Implementation).

D. Fentanyl or morphine and midazolam shall be secured on the ALS units under double lock. Provider agencies that have more than one approved ALS unit must have unique double locking mechanisms for each ALS unit.

E. Provider agencies utilizing ADS must adhere to the following:

1. Each ADS location must be registered with the Drug Enforcement Agency (DEA) .

2. Must comply with all record keeping and security requirements imposed under current regulations.

~~E~~ F.. Daily Inventory Procedures of controlled substances on an ALS unit

1. Controlled drugs shall be inventoried by two paramedics at least daily and anytime there is a change in personnel.

2. The key to access controlled drugs shall be in the custody of the individual who performed the inventory.

3. The Daily Controlled Drug and Key Inventory Form, ~~Reference~~ Ref. No. 702.2 or its equivalent, shall be co-signed with the names of the relinquishing and the receiving paramedic. Entries shall be in blue or black ink only.

4. ~~NOTE:~~ Errors shall be corrected by drawing a single line through the incorrect wording; the writing underneath the single line must remain readable. The individual making the change should initial adjacent to their correction. Correction fluid or other erasure material is not permitted.

~~4.~~5. The Daily Controlled Drug and Key Inventory Form, Reference No. 702.2 or its equivalent, must be maintained by the provider agency for a minimum of three years. An entry shall be made on this form for each of the following situations:

a. Change of shift.

b. Any change to the narcotic inventory.

c. Any time there is a change of responsible personnel

d. ~~**NOTE:**~~ Providers authorized to participate in the 1:1 Staffing Program for Interfacility Transports are required to inventory controlled drugs at the end of the specified shift, when two paramedics are available to count and co-sign for the drugs.

6. Provider agencies that restock controlled drugs from County operated pharmacies shall forward copies of Reference No. 702.2, Monthly Controlled Drug Storage Inspection Form or its equivalent, to their assigned DHS pharmacy no later than the 30th day of the following month.

F. Lost or Missing Controlled Substances

1. Issued by a County Operated Pharmacy

a. Any lost or missing controlled substances or discrepancy in the controlled drug count is to be reported by the following business day to the Department of Health (DHS) pharmacy that supplied the drugs and the EMS Agency. The follow up paperwork shall be submitted within five business days.

b. A police report is required for any suspected lost or missing controlled substances.

c. Any loss of or discrepancy shall also be reported to the paramedic coordinator, and the Provider Agency Medical Director or other authorized physician.

d. Any lost or missing controlled substances shall be documented on Reference No. 702.5 Missing Lost Controlled Drug Pharmacy Reporting Form, and shall initiate supervisory review at the involved provider agency. The original of the completed form will be presented to the DHS pharmacy that dispensed the drugs.

e. Replacement of lost or missing controlled substances requires that all investigative documentation be submitted to the EMS Agency (police report, personnel statements, supervisor's follow-up, processes implemented to decrease the likelihood of future occurrences, etc.). Upon review and approval of the documentation, the EMS Agency will provide written authorization for replacement of the controlled substance(s).

f. If a provider agency's internal investigation into a controlled drug loss exceeds thirty days, the provider shall submit a status update to the issuing DHS pharmacy and the EMS Agency at the 30th day.

2. Authorized by a Provider Agency Medical Director or Drug Authorizing Physician.

a. Provider agencies approved to operate under Ref. No. 702.4 shall have policies/procedures in place consistent with local, state, and federal regulations on mandated reporting.

b. Any lost, missing or discrepancy shall be reported by the following business day to the paramedic coordinator, the EMS Agency and the authorizing Provider Agency Medical Director or Drug Authorizing Physician.

c. Any significant loss, breakage or discrepancy in the count requires notification to the ~~Drug Enforcement Administration~~DEA, utilizing DEA Form 106 or electronically via the DEA web site, within one business day of discovery.

d. Any loss shall initiate supervisory review at the involved provider agency. If a provider agency's internal investigation into a controlled drug loss exceeds 30 days, the provider shall submit a status update to the Provider Agency Medical Director and the EMS Agency at the 30th day.

G. Disposal of controlled substances issued by a non-county pharmacy

1. The provider agency shall dispose of expired controlled substances through one, or a combination of the following:

a. Utilizing a DEA licensed pharmaceutical reverse distributor.

b. Following the guidelines outlined in the Code of Federal Regulations, Section 1307.21, Procedure for Disposing of Controlled Substances.

V. Record Keeping

A. All controlled drugs issued to a provider agency must be accounted for. The provider agency shall retain a copy of the EMS Report Form (or an ePCR) for each patient to whom a controlled drug was administered and maintain it with any completed Missing/Expired Controlled Drug Reporting Forms, drug orders, invoices or other associated documentation in a separate file for a minimum of three years.

B. Each controlled drug use must be documented on the EMS Report Form (or ePCR). If the total amount of the drug is not administered, the remaining amount shall be wasted at the receiving facility as follows:

1. Document wasted narcotics (partial or whole) in the "Narcotic Waste/Witness" section of the EMS Report Form or ePCR, including the amount wasted.

2. Obtain the printed name and signature of the witness who observed the disposal of the remaining solution. (registered nurse, physician, pharmacist).

C. In addition to the local EMS Agency and the provider agency, controlled drug inventories and logs are subject to inspection by the issuing pharmacy, the California Board of Pharmacy, and agents of the Bureau of Narcotic Enforcement Administration of the Department of Justice, Federal Drug Enforcement Administration.

CROSS REFERENCES**:**

Prehospital Care Manual:

Reference No. 410, **Provider Agency Drug Authorizing Physician**
Reference No. 411, **Provider Agency Medical Director**
Reference No. 606, **Documentation of Prehospital Care**
Reference No. 607, **Electronic Submission of Prehospital Data**
Reference No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Reference No. 702.1, **Expired/Broken Controlled Drug Pharmacy Reporting Form**
Reference No. 702.2, **Daily Controlled Drug and Key Inventory Form (Page 1 of 2) Monthly Drug Storage Inspection Form (Page 2 of 2)**
Reference No. 702.3, **County Operated Pharmacy Contact Numbers for Reporting Loss of Controlled Drugs**
Reference No. 702.4, **Provider Agency Medical Director Notification of Controlled Substance Program Implementation**
Reference NO. 702.5 **Lost/Missing Controlled Drug Pharmacy Reporting Form**

Treatment Protocol: TABLE OF CONTENTS **Ref. No. 1200**

Treatment Protocol: TABLE OF CONTENTS **Ref. No. 1200**

Treatment Protocol: TABLE OF CONTENTS — Ref. No. 1200

Notes

1 Medical Device Malfunction for children may include but is not limited to: Ventriculoperitoneal shunts, vagal nerve stimulators, G-tubes, central lines, and LVADs)
2 Cardiac Arrest Obvious Death for children includes SIDS
3 Hyperthermia for children includes child trapped in vehicle
4 Airway Obstruction for children includes aspirated foreign body and tracheostomy obstruction
5 Respiratory Distress for children includes stridor/croup
6 Traumatic injury – Multisystem/Torso Trauma includes suspected child maltreatment

Elements of General ALS may be repeated in individual protocols

Treatment Protocol: GENERAL INSTRUCTIONS Ref. No. 1200.1

The Treatment Protocols were developed ~~by combining the Base Hospital Treatment Guidelines (BHTG) and the Standing Field Treatment Protocols (SFTP)~~ to be consistent with EMS Provider Impressions as approved by the California EMS Authority. The foundations for the revised guidelines are the paramedic scope of practice, medical research, and community standards in medical practice. ~~A sign/symptom orientation to treating the prehospital care patient has been retained.~~

GENERAL INFORMATION

1. Patients with the same disease may have differing symptoms and presentations, and conversely, patients with similar signs and symptoms may have very different diagnosis.

2. The Treatment Protocols guide treatment of "classic" presentations based on evidence-based practice. Base hospital physicians, mobile intensive care nurses (MICNs) and paramedics must utilize their medical knowledge, expertise and critical thinking to determine appropriate treatment for each patient.

3. The protocols were not developed with the intent that all therapies be done on scene. Transport of patients with treatment en route is left to the discretion of the base hospital and the field unit.

4. The protocols incorporate current policies that address "Procedures Prior to Base Contact", "Base Hospital Contact and Transport Criteria", and "Standing Field Treatment Protocols". It is the goal to ultimately transition all the concepts and requirements in the above policies into these new protocols.

PROTOCOL FORMAT

1. Pharmacologic agents are in **bold** typeface.

2. ~~Pediatric treatments are preceded by the Los Angeles County Emergency Department Approved for Pediatrics (EDAP) teddy bear symbol.~~ In general, each protocol will have a corresponding pediatric specific protocol. The pediatric protocols are identified with a letter "P" at the end of the protocol number and have the Los Angeles County teddy bear symbol.

3. ~~Paramedics must measure all pediatric patients using a length-based resuscitation tape (e.g., Broselow) and report the identified color code and weight in kilograms when contacting the base hospital. The color and weight in kilograms are documented on the EMS Report Form in the patient weight section. Medication dosages are then determined by correlating the length-based resuscitation tape color with the appropriate weight on the Color Code Drug Doses/L.A. County Kids chart or the pediatric doses in the Drug Administration section. If the child is longer than the length-based resuscitation tape, use adult dosing.~~ Moved to USING TREATMENT PROTOCOLS section.

4. ~~The Special Considerations section has additional helpful information specific to the chief complaint and/or specific patient population.~~
   In preparation for an on-line mobile application, the protocols were developed to provide linkages to additional helpful information specific to the provider impression and/or specific patient population such as the Medical Control Guidelines (MCG) and patient destination policies. These

are indicated in the protocols as hyperlinks.

USING THE TREATMENT PROTOCOLS

~~Determine the patient's chief complaint or problem and then identify the protocol that best meets their needs.~~

1. ~~The treatment protocol sequence is intended to guide the priority in which interventions are administered.~~
   Utilize Ref. No. 1201, General ALS as a starting point for every patient encounter.

2. If more than one treatment protocol applies, begin by using the one most closely associated with the patient's primary complaint. Utilize Reference No. 806.1, Procedures Prior to Base Contact, as indicated and refer to other treatment protocols as needed.
   Based on the patient presentation and the Paramedic's assessment, the Paramedic determines his/her Provider Impression. In general, the Provider Impressions are categorized according to general body systems. Each Provider Impression has a corresponding Treatment Protocol.

   BODY SYSTEM
   └→ Provider Impression/Protocol Name ⟶ Protocol Number

   Some provider Impressions have more than one protocol associated with it; for example 1222.1 Bradycardia has a separate protocol from 1222.2 Tachycardia, these are noted in italics, but the Provider Impression for both would be Cardiac Dysrhythmia.

   CARDIOVASCULAR / CHEST PAIN
   ├→ Cardiac Dysrhythmia – *Bradycardia* ⟶ 1222.1 1222.1-P
   └→ Cardiac Dysrhythmia – *Tachycardia* ⟶ 1222.2 1222.2-P

3. ~~If the patient's status changes, a different treatment protocol might be needed. Select the new treatment protocol by taking into account the treatments already performed~~.
   Refer to the appropriate Treatment Protocol(s) to guide patient treatment. The treatment protocol sequence is intended to guide the priority in which interventions are administered but not to imply a strict order as priorities in an individual patient may differ.

4. If the patient's status changes, a different treatment protocol might be needed. Select the new treatment protocol by taking into account the treatments already performed.

5. Paramedics must measure all pediatric patients using a length-based resuscitation tape (e.g., Broselow) and report the identified color code and weight in kilograms when contacting the base hospital. The color and weight in kilograms are documented on the EMS Patient Care Record in the patient weight section. Medication dosages are determined by correlating the length-based resuscitation tape color with the appropriate weight on the Medical Control Guideline (MCG) 1309, Color Code Drug Doses/L.A. County Kids chart. If the child is longer than the length-based resuscitation tape, use adult dosing.

6. ~~Not all the treatment protocols have an SFTP component. Some have only procedures that can be done under Ref. No. 806.1 and then base contact is required. Report the treatment protocol number or name when making base contact such as, "we have a crush injury and are utilizing~~

~~Ref. No. 1277" or "we are using the crush injury treatment protocol".~~

~~7. The SFTP portion of the treatment protocols can only be used by approved SFTP provider agencies.~~

CONTACT THE BASE HOSPITAL WHEN:

1. ~~Patient meets Ref. No. 808, Base Hospital Contact and Transport Criteria, Section I~~ Specified by the treatment protocol

2. ~~ALS intervention is performed and the provider agency is not an authorized SFTP provider~~

3. Additional or unlisted treatments are required

4. Consultation with the base hospital would be helpful

5. ~~ST Elevation Myocardial Infarction (STEMI) notification and destination are required~~ (STEMI notification will be specified in the Chest Pain – STEMI protocol)

6. Presentation where the provider impression and the appropriate protocol are unclear

7. ~~Stroke notification, last known well date and time, and destination are required~~ (Stroke notification will be specified in the Stroke/CVA/TIA Treatment Protocol)

8. 5 or more patients requiring transport (contacting the MAC constitutes base contact)

9. Patients who meet Trauma Center Criteria/Guidelines *(Ref. No. 506)*

10. Patients who refuse transport (AMA) and meet any criteria requiring base hospital contact as specified in the treatment protocol. This includes parents or legal guardians who refuses transport of a pediatric patient.

11. Children 13-36 months of age except isolated minor extremity injury

12. Critically ill pediatric patients who meet transport guidelines to a Pediatric Medical Center *(Ref. No. 510)*

~~STANDING FIELD TREATMENT PROTOCOL (SFTP) PROVIDERS~~

~~Additional treatments that can be performed by an approved SFTP provider prior to base contact are identified by **"Continue SFTP or Base Contact".** All subsequent treatments may be performed until the paramedic reaches the notation **"Establish Base Contact"**. Once **"Establish Base Contact All"** appears, all ensuing treatments require an order from the base hospital.~~

~~The following dysrhythmias require establishing base hospital contact:~~

- ~~Symptomatic Bradycardia~~
- ~~Supraventricular Tachycardia (SVT)~~
- ~~Ventricular Tachycardia (contact not required if utilizing Cardiac Arrest protocol and no pulse is~~

~~present)~~
- ~~Ventricular Fibrillation~~
- ~~Second and Third Degree Heart Blocks~~
- ~~Symptomatic Atrial Fibrillation/Atrial Flutter~~

If base hospital contact is made to obtain patient care orders, a full patient report will be given. If the patient meets trauma guidelines but is being transported to a non-trauma hospital, a full patient report must be given. Once base hospital contact is made for medical control, all subsequent treatments listed in the protocol require base hospital order.
If base hospital contact is made to obtain patient care orders, a full patient report will be given. If the patient meets trauma guidelines but is being transported to a non-trauma hospital, a full patient report must be given. Once base hospital contact is made for medical control, all subsequent treatments listed in the protocol require base hospital order.

~~It is the expectation when providing receiving hospital report for patient notification only, the following minimal patient information will be provided:~~ (This section will be made into a Medical Control Guideline)

~~All Patients~~
~~Provider Code/Unit #~~
~~Sequence Number~~
~~Location (if 9-1-1 transfer)~~
~~Chief complaint~~
~~Age and units~~
~~Gender~~
~~Level of distress~~
~~Name of the protocol (number optional)~~
~~Glasgow Coma Scale (GCS), if altered~~
~~Airway adjuncts utilized, if applicable~~
~~Destination/ETA~~

~~Additional information if:~~
~~Trauma Complaint and transporting to a trauma center~~
~~Mechanism of injury~~
~~Location of injuries/pertinent information (flail segment, rigid abdomen, evisceration, etc.)~~
~~Complete vital signs and GCS~~

~~Pediatric~~
~~Pediatric Weight (in kg from weight-based tape) and Color Code (if applicable)~~

~~STEMI~~
~~12-Lead ECG rhythm/interpretation if the 12-lead ECG indicates STEMI, to include quality of tracing~~

~~mLAPSS (modified Los Angeles Prehospital Stroke Screen) performed:~~
~~If positive/met~~
~~Last known well date and time~~
~~Blood glucose~~

~~LAMS (Los Angeles Motor Scale) score, if applicable~~

Treatment Protocol: GENERAL INSTRUCTIONS Ref. No. 1200.1

Paramedic on-line report to the base hospital shall be in accordance with Reference No. 1307, Medical Control Guideline: Base Hospital Report – To be developed

Hospital notification shall be in accordance with Reference No. 1332, Medical Control Guideline: Notification of the 9-1-1 Receiving Facility – To be developed

Treatment Protocol: GENERAL ALS — Ref. No. 1201

1. Use appropriate PPE precautions – gloves and additional protective equipment as indicated
2. Assess scene for potential hazards and number of patients
3. Activate additional resources for MCI, HAZMAT, Law enforcement, etc. if necessary
4. Assess airway and level of alertness and provide basic airway management as necessary *(MCG 1304, Airway/Oxygen/Ventilation)*
    - Airway management should include pulse oximetry and oxygen administration if indicated
5. If patient is unresponsive, assess for pulse and begin CPR if necessary. Determine death if appropriate.
6. Control external hemorrhage/bleeding if severe *(MCG 1314, Traumatic Hemorrhage Control)*
7. For patients with suspected trauma, provide spinal immobilization as indicated *(MCG 1334, Spinal Motion Restriction)*
8. Advanced airway and respiratory management as necessary *(MCG 1304, Airway/Oxygen/Ventilation)*
9. Assess and document pain *(MCG 1326, Pain Assessment)*
10. Determine Provider Impression. Refer to appropriate Treatment Protocol(s) to guide patient management *(Ref. No. 1200 Treatment Protocols Table of Contents)*
11. Establish Base Hospital Contact as indicated per protocol, or in case of difficulty determining appropriate protocol(s) to use.

Treatment Protocol: GENERAL ALS **Ref. No. 1201-P**

1. Use appropriate PPE precautions – gloves and additional protective equipment as indicated
2. Assess scene for potential hazards, potential for child maltreatment or neglect, and number of patients
3. Activate additional resources for MCI, HAZMAT, Law enforcement (Scene safety or child maltreatment), etc. if necessary
4. Assess airway and level of alertness and provide basic airway management as necessary *(MCG 1304, Airway/Oxygen/Ventilation)*
    - Airway management should include pulse oximetry and oxygen administration if indicated
5. Assess pediatric patients as per *(MCG 1328, Pediatric Patients)*
6. If patient is unresponsive, assess for pulse and begin CPR if necessary. Determine death if appropriate.
7. Control external hemorrhage/bleeding if severe *(MCG 1314, Traumatic Hemorrhage Control)*
8. For patients with suspected trauma, provide spinal immobilization as indicated *(MCG 1334, Spinal Motion Restriction)*
9. Advanced airway and respiratory management as necessary *(MCG 1304, Airway/Oxygen/Ventilation)*
10. Assess and document pain *(MCG 1326, Pain Assessment)*
11. Determine weight in kg as per *(MCG 1309, Color Code Drug Doses/L.A. County Kids)*
12. Determine Provider Impression. Refer to appropriate Treatment Protocol(s) to guide patient management *(Ref. No. 1200 Treatment Protocols Table of Contents)*
13. Establish Base Hospital Contact as indicated per protocol, or in case of difficulty determining appropriate protocol(s) for use.

Treatment Protocol: AIRWAY OBSTRUCTION Ref. No. 1270

1. Assess the patient's airway and initiate basic airway maneuvers *(MCG 1304)*
    - Continually assess patient's airway and ventilation status

2. Administer **Oxygen** *(MCG 1304)*
    - High flow O_2 for patients with impending respiratory arrest due to severe airway obstruction

3. Advanced airway maneuvers if unable to ventilate effectively with basic airway maneuvers *(MCG 1304)*

Base Hospital Contact recommended for all patients with airway obstruction, required for patients in moderate-to-severe respiratory distress, poor perfusion and/or altered mental status

4. If patient has an Unmanageable Airway *(MCG 1304)*
   Immediate transport to the MAR and Base Hospital Contact

5. Cardiac monitoring, initiate simultaneously when resources allow *(MCG 1308)*

6. If patient is conscious and spontaneous ventilations are adequate:
    - For airway edema and/or stridor, administer
      Epinephrine (1mg/mL concentration) 5 mg via hand-held nebulizer
    - Establish ALS monitoring in position of comfort
    - Prepare to manage airway if patient's condition deteriorates

7. If patient is unconscious and/or spontaneous ventilations are inadequate:
    - Continue basic and/or advanced airway maneuvers as indicated
    - Consider physical obstruction from foreign body
        - Initiate CPR for unresponsive victims with foreign body obstruction
        - Perform direct laryngoscopy to visualize potential obstruction when indicated
        - Remove visible foreign body with Magill forceps
    - Consider airway edema (swelling)
        - For suspected anaphylaxis refer to *Treatment Protocol 1241*
        - For visible airway swelling and/or stridor administer
          Epinephrine (1mg/mL concentration) 0.5mg IM
          May repeat in 10 minutes for a total of two doses

8. Vascular access *(MCG 1339)*